HALF HOLLOW HILLS CENTRAL SCHOOL DISTRICT

PLEASE BE AWARE THAT IT IS A ***CRIME*** TO FRAUDULENTLY REGISTER A CHILD IN A SCHOOL DISTRICT OTHER THAN THE DISTRICT IN WHICH THE PARENTS OR LEGAL GUARDIANS RESIDE. THE HALF HOLLOW HILLS CENTRAL SCHOOL DISTRICT IS COMMITTED TO THE PREVENTION, TERMINATION AND PROSECUTION OF ANY SUCH ACTIVITY

WELCOME

We are pleased to welcome you to the Half Hollow Hills Central School District. Children age 5 on or before December 31st will be eligible for admission to kindergarten the preceding September. In order to safeguard the health of your youngster, to place him or her in the most appropriate program, and to conform with New York State Laws and district policy, we will need certain information and records. These include:

REQUIREMENTS FOR REGISTRATION
ABSOLUTELY NO EXCEPTIONS WILL BE MADE

Homeowners
Please provide any of the following:
House Deed
Suffolk County Tax Bill
Sales Contract w/ Attorney Letter
Mortgage Statement

Renters Must
Provide the following:
Current Lease
Landlord's Affidavit, and new change of address on license from the DMV

And both Homeowners and Renters MUST provide two of the following:

Telephone/Cell phone bill
Water bill/LIPA bill
Cablevision bill
Credit card statement
Bank statement/ Government issued notices

DOCUMENTS FOR CHILD

1. Birth Certificate
2. Proof of mandatory immunization (see attached form)
3. Parental guardianship – Copies of court papers
4. All Foster Parents must submit, at registration, a letter from the placement agency indicating the licensed foster parents and form DSS 2999 completed by the placement agency .
5. Transfer card or report card showing proof of grade level for transfer student.

Registration is not complete until all necessary information and documentation is provided to the school your child will attend

HALF HOLLOW HILLS SCHOOL DISTRICT
HOUSING QUESTIONNAIRE

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____ / ____ / ____ Grade: _____ ID#: _____
Month Day Year *(preschool-12)* *(optional)*

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Please check **one** box.*)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____
- ☐ In permanent housing

_____ _____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Date

Half Hollow Hills
Central School District

School Use Only

Date Entered _____

Grade _____

Homeroom _____

Handicap Code _____

REGISTRATION FORM

THIS FORM IS A LEGAL DOCUMENT OF THE HALF HOLLOW HILLS CENTRAL SCHOOL DISTRICT TO VERIFY THE RESIDENCE OF STUDENTS AND PARENTAL OR GUARDIANSHIP RESPONSIBILITY.

SCHOOL _____ CENSUS AREA _____ PRESENT GRADE _____

STUDENT'S NAME _____ SEX _____ DATE OF REGISTRATION _____
Last *First* *MI*

DATE OF BIRTH _____ AGE _____ PLACE OF BIRTH _____ ETHNIC # _____

ADDRESS _____ PROOF OF RESIDENCE _____
Street

_____ HOME PHONE NUMBER ( )
Town *Zip Code*

PREVIOUS RESIDENCE _____ EMERGENCY PHONE NUMBER ( )

LAST SCHOOL ATTENDED (PLEASE GIVE NAME AND ADDRESS) _____

_____

FATHER'S NAME _____ BIRTHPLACE _____

PLEASE CHECK IF ☐ FOSTER PARENT ☐ LEGAL GUARDIAN

DAY PHONE: _____

EVENING PHONE: _____

MOTHER'S NAME _____ BIRTHPLACE _____

PLEASE CHECK IF ☐ FOSTER PARENT ☐ LEGAL GUARDIAN

DAY PHONE: _____

EVENING PHONE: _____

MOTHER/FATHER: **IN THE EVENT OF DIVORCE OR SEPARATION, BOTH PARENTS HAVE EQUAL ACCESS TO THEIR CHILDREN AND INFORMATION ABOUT THEM, UNLESS CURRENT COURT ORDERS ARE FILED WITH THE SCHOOL LIMITING THIS.**

FAMILY AND/OR HOUSEHOLD MEMBERS:

NAME	BIRTH DATE	RELATIONSHIP	SCHOOL ATTENDING	GRADE

EXACT LOCATION OF HOME: (PINPOINT THE NEAREST INTERSECTION TO YOUR HOME)

_____

WAS YOUR CHILD EVER IN A SPECIAL CLASS OR LEARNING RESOURCE CENTER? _____

IF YES, WHEN AND WHERE: _____

HAS YOUR CHILD EVER BEEN DESIGNATED AS HAVING A DISABILITY? _____

IF YES, SPECIFY: _____

FAMILY DOCTOR: _____ PHONE: _____

ADDRESS: _____

I CERTIFY THAT THE INFORMATION PRESENTED ABOVE IS ACCURATE AND SUBJECT TO VERIFICATION. I UNDERSTAND THAT ANY FALSIFICATION OR MISREPRESENTATION OF INFORMATION REGARDING RESIDENCE COULD BE GROUNDS FOR EXCLUSION OF THE STUDENT AND THAT THE DISTRICT WILL PURSUE LEGAL AND FINANCIAL RECOURSE TO RECOVER EXPENSES.

_____ _____

Signature *Relationship To Student*

ORIGINAL

DISTRICT OF RESIDENCE ADDENDUM

Date_____

Name of Student_____

Date of Birth_____

As of October 7, 2018 what was your district of residence?

_____

Previous School district_____

Name of School_____

Address of School District_____

_____

Office use only
School Code
New York City students

Return form to your child's school or mail to:
Half Hollow Hills CSD
525 Half Hollow Road, Dix Hills, NY 11746
Attn: MIS Department

HOUSEHOLD INFORMATION FORM

For internal use
Household ID # _____

☐ Check this box if you are a new registrant ☐ Check this box if you are requesting an activation key ☐ Check this box if you wish to change phone/email/contacts

Primary Household Address_____ School Year _____
Town_____ Zip_____ Primary Household Phone:_____

Children in the Household:

Name of Child	Date of Birth	School Attending (if any)	Grade

Parent/s or Guardian Information:

Name	Address if different than Primary Household Address	Home Phone if different than Primary Household Phone	Work Phone	Cell Phone	Email address (Important)
Mother First name: Last name:					
Father First name: Last name:					

Other Persons who live in this Household: (e.g. Step-parent, Grandparent)

Name	Relationship to children in the Household	Work Phone	Cell Phone	Comments

Emergency Contacts not living in the Household:

Name	Relationship to children in the Household	Home Phone	Work Phone	Cell Phone	Comments

For additional information or comments use the back of this form.

Parent/ Guardian (print name)_____ Signature_____ Date_____

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:			
First	*Middle*	*Last*	
DATE OF BIRTH:			GENDER:
Month	*Day*	*Year*	❑ Male ❑ Female
PARENT/PERSON IN PARENTAL RELATION INFO:			
Last Name	*First Name*		*Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other *specify*		
2. What was the first language your child learned?	❑ English	❑ Other *specify*		
3. What is the Home Language of each parent/guardian?	❑ Mother *specify*	❑ Father *specify*	❑ Guardian(s) *specify*	
4. What language(s) does your child understand?	❑ English	❑ Other *specify*		
5. What language(s) does your child speak?	❑ English	❑ Other *specify*	❑ Does not speak	
6. What language(s) does your child read?	❑ English	❑ Other *specify*	❑ Does not read	
7. What language(s) does your child write?	❑ English	❑ Other *specify*	❑ Does not write	

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School *Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ❑ *No* ❑ *Not sure* ❑ *If yes, please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been ***referred*** for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever ***received*** any special education services in the past?
❑ No ❑ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation *Date*

Relationship to student: ❑ Mother ❑ Father ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

**DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

NEW YORK STATE | Department of Health | Office of Children and Family Services | State Education Department

June 14, 2019

Statement on Legislation Removing Non-Medical Exemption from School Vaccination Requirements

On June 13, 2019, Governor Andrew M. Cuomo signed legislation removing non-medical exemptions from school vaccination requirements for children. The United States is currently experiencing the worst outbreak of measles in more than 25 years, with outbreaks in pockets of New York primarily driving the crisis. As a result of non-medical vaccination exemptions, many communities across New York have unacceptably low rates of vaccination, and those unvaccinated children can often attend school where they may spread the disease to other unvaccinated students, some of whom cannot receive vaccines due to medical conditions. This new law will help protect the public amid this ongoing outbreak.

What did the new law do?

As of June 13, 2019, there is no longer a religious exemption to the requirement that children be vaccinated against measles and other diseases to attend either:

- public, private or parochial school (for students in pre-kindergarten through 12th grade), or
- child day care settings.

For those children who had a religious exemption to vaccination, what are the deadlines for being vaccinated?

Children who are attending child day care or public, private or parochial school, and who had a religious exemption to required immunizations, must now receive the first age appropriate dose in each immunization series by June 28, 2019 to attend or remain in school or child day care. Also, by July 14, 2019 parents and guardians of such children must show that they have made appointments for all required follow-up doses. The deadlines for follow-up doses depend on the vaccine. The New York State Department of Health follows the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices catch-up immunization schedule and expects children to receive required doses consistent with Table 2 at the following link in order to continue to attend school or child day care: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

What is the deadline for first dose vaccinations if my child is not attending school until September?

Parents and guardians of all children who do not have their required immunizations are encouraged to have them receive the first dose as soon as possible. The deadline for obtaining first dose vaccinations for children attending school in the fall is 14 days from the first day of school. Within 30 days of the first day of school, parents and guardians of such children must show that they have made appointments for all required follow-up doses.

Additional information will be forthcoming.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI _____ kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:			DOB:
SCREENINGS			
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** ~~Use the Interscholastic Sports Categories (below) for Restrictions or modifications~~

☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

~~Medical Provider~~ Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

NEW YORK STATE EDUCATION DEPARTMENT
STUDENT RACIAL AND ETHNIC IDENTIFICATION

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Name of School:

School District Student Identification Number:	**Date of Birth (Month/Day/Year):** / /
Student Name: Last, First, Middle:	**Grade Level:**

DIRECTIONS TO PARENT/GUARDIAN: PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND.

1. **Is the student Hispanic, Latino, or of Spanish origin?** Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race. For question 1 check (√) the box that best describes your child. Check (√) only ONE box.

   ☐ **YES, Hispanic** ☐ **NO, not Hispanic**

2. **Select one or more races from the following five racial groups.** For question 2 check (√) all groups that apply to your child; check (√) **at least** ONE box:

   ☐ **AMERICAN INDIAN OR ALASKA NATIVE**: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

   ☐ **ASIAN**: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

   ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

   ☐ **BLACK OR AFRICAN AMERICAN**: A person having origins in any of the Black racial groups of Africa.

   ☐ **WHITE**: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

_____ _____

Signature of Parent/Guardian/Other Date

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify): _____

The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations provided for by the Family Educational Rights and Privacy Act (1974) which prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

HALF HOLLOW HILLS CENTRAL SCHOOL DISTRICT
OF HUNTINGTON AND BABYLON

December 2018

Dear Parents/Guardians

We are writing to inform you about your rights as parents or guardians pursuant to Section 4402 of the Education Law. You have the right to refer you child for special education evaluations and services should you suspect that your child has a disability. Special educations includes specially designed instruction or special services or programs to meet the unique needs of students with disabilities. A parent or guardian who is concerned about his or her child's academic performance due to a disability may refer his or her child for a special education evaluation to determine whether he or she is in need of special education services. More specific information regarding referral and evaluation can be found in the New York State Education Department's handbook, "A Parent's Guide to Special Education," available in English at www.p12.nysed.gov/specialed/publications/policy /parentsguide.pdf and in Spanish at www.p12.nysed.gov/specialed/pujblications/policy/SpanishParentGuide.pdf.

You may also contact our district's Executive Director of Special Education, Allison Strand, at 631-592-3045 for any questions you may have. We look forward to partnering with you to ensure that your child has a successful experience with our school district.

Very truly yours,

Patrick Harrigan

Dr. Patrick Harrigan

Superintendent of Schools

525 HALF HOLLOW ROAD • DIX HILLS, NEW YORK 11746

HALF HOLLOW HILLS SCHOOL DISTRICT
NEW STUDENT REGISTRATION
MIGRANT ELIGIBILITY SCREENING

Has anyone in your family worked or looked for work at the following occupations within the last three years?

- ☐ Any agricultural or farm work (such as hay, dairy, fruit or vegetable crops, poultry, fish farming, nursery/greenhouse)
- ☐ Work related to logging, timber growing or harvesting
- ☐ Work at food processing plant (such as vegetable or poultry processing plants packing apples or vegetables)

If you checked any of the boxes above, please provide contact information below:

Parent's/Guardian's name: _____

Home address: _____

_____

Telephone number: (_____) _____-_____ Best time to be reached: _____AM/PM

Previous Address: _____

Student name	Age	Grade
Student name	Age	Grade
Student name	Age	Grade

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, regardless of their nationality or legal status. This program is free of charge to all eligible families and may include tutoring, free lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

HALF HOLLOW HILLS SCHOOL DISTRICT
NEW STUDENT REGISTRATION
MIGRANT ELIGIBILITY SCREENING

¿Usted o algún miembro de su familia ha trabajado o buscado trabajo en algunas de las siguientes ocupaciones en los pasados tres años?

- ☐ Cualquier trabajo Agrícola (como plantando, seleccionando, cosechando frutas o vegetales, cultivando o cortando flores o árboles). Trabajando en una lechería.

- ☐ Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.

Si usted contestó que SI, por favor complete la siguiente información:

Nombre del Padre, Encargado o Trabajador: _____

Dirección Física: _____

Teléfono: (_____) _____-_____ Mejor tiempo para ser contactado: _____AM/PM

Dirección anterior: _____

Nombre del estudiante	Edad	Grado

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Acta de Educación Elemental y Secundaria (ESEA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, ***sin importar su nacionalidad o estado legal****. Este programa* ***es gratuito*** *para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito, excursiones, escuela de verano, actividades de envolvimiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.*